

|  |             |                                  |              |                             |      |
|--|-------------|----------------------------------|--------------|-----------------------------|------|
| <b>PATIENT<br/>REFERRAL</b>                  | INCIDENT    | REPORTING<br>UNIT                | <b>ESF-9</b> | FORM<br><b>US&amp;R—014</b> | 2/95 |
| DISASTER #:                                  | OPS PERIOD: | DATE/TIME PREPARED:              | PREPARED BY: |                             |      |
| NAME:  |             | TASK FORCE:                      |              |                             |      |
| Patient Log #:                               |             | Time/Date of referral/admission: |              |                             |      |
| Facility/Hospital:                           |             | Phone number:                    |              |                             |      |
| Referral MD:                                 |             | Phone & Pager numbers:           |              |                             |      |
| Complaint:                                   |             |                                  |              |                             |      |
| Condition:                                   |             |                                  |              |                             |      |
| Disposition:                                 |             |                                  |              |                             |      |
|  |             |                                  |              |                             |      |
| NAME:  |             | TASK FORCE:                      |              |                             |      |
| Patient Log #:                               |             | Time/Date of referral/admission: |              |                             |      |
| Facility/Hospital:                           |             | Phone number:                    |              |                             |      |
| Referral MD:                                 |             | Phone & Pager numbers:           |              |                             |      |
| Complaint:                                   |             |                                  |              |                             |      |
| Condition:                                   |             |                                  |              |                             |      |
| Disposition:                                 |             |                                  |              |                             |      |
|  |             |                                  |              |                             |      |
| NAME:  |             | TASK FORCE:                      |              |                             |      |
| Patient Log #:                               |             | Time/Date of referral/admission: |              |                             |      |
| Facility/Hospital:                           |             | Phone number:                    |              |                             |      |
| Referral MD:                                 |             | Phone & Pager numbers:           |              |                             |      |
| Complaint:                                   |             |                                  |              |                             |      |
| Condition:                                   |             |                                  |              |                             |      |
| Disposition:                                 |             |                                  |              |                             |      |
|  |             |                                  |              |                             |      |
| NAME:  |             | TASK FORCE:                      |              |                             |      |
| Patient Log #:                               |             | Time/Date of referral/admission: |              |                             |      |
| Facility/Hospital:                           |             | Phone number:                    |              |                             |      |
| Referral MD:                                 |             | Phone & Pager numbers:           |              |                             |      |
| Complaint:                                   |             |                                  |              |                             |      |
| Condition:                                   |             |                                  |              |                             |      |
| Disposition:                                 |             |                                  |              |                             |      |
|  |             |                                  |              |                             |      |
| NAME:  |             | TASK FORCE:                      |              |                             |      |
| Patient Log #:                               |             | Time/Date of referral/admission: |              |                             |      |
| Facility/Hospital:                           |             | Phone number:                    |              |                             |      |
| Referral MD:                                 |             | Phone & Pager numbers:           |              |                             |      |
| Complaint:                                   |             |                                  |              |                             |      |
| Condition:                                   |             |                                  |              |                             |      |
| Disposition:                                 |             |                                  |              |                             |      |
|  |             |                                  |              |                             |      |
| <b>EMPLOYEE USE ONLY — NOT FOR CIVILIANS</b> |             |                                  |              |                             |      |

## **PATIENT REFERRAL TRACKING FORM**

This form is designed to be used by the Task Force Medical Team and the Incident Support Team Medical Officer to track both Task Force personnel and other patients (including recovered victims) treated by Task Force medical teams and referred on for further medical evaluation or care. A copy of this form will be maintained by each Task Force Medical Team and submitted on a daily basis to the IST Medical Officer. The IST Medical Officer will collate the information and keep the medical teams and the IST Leader updated on the aggregate information.